OPTUMCare
Medical Group

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

For the purpose of treatment, making payment for such treatment, and other related health care operation functions
I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient

PRINT PATIENT LAST NAME	FIRST	BIRTHDATE
ADDRESS	CITY	STATE ZIP CODE
PREVIOUS LAST NAME OR ALIAS PROVIDED FOR PRIOR TREATMANTS	PHONE NUMBER	ALTERNATE PHONE NUMBER

I HEREBY AUTHORIZE THE RELEASE OF MY HEALTH RECORDS (PHI) FROM
(senders contact information and complete mailing address)

NAME OF PHYSICIAN/HEALTH CARE PROVIDER/OTHER	
ADDRESS	
CITY/STATE/ZIP CODE	
PHONE NUMBER	FAX NUMBER

FURNISH THE RECORDS (PHI) TO
(recipients contact information and complete mailing address)

NAME OF PHYSICIAN/HEALTH CARE PROVIDER/OTHER	
ADDRESS	
CITY/STATE/ZIP CODE	
PHONE NUMBER	FAX NUMBER

THIS REQUEST AND AUTHORIZATION APPLIES TO (must make a selection to be valid)**:**

- ☐ All healthcare information
- ☐ Healthcare information relating to the following treatment, condition, or dates: From_____ to _____.
- ☐ Other: _____

☐ Yes ☐ No To authorize the release of my STD results, HIV/AIDS test, whether negative or positive, to the person(s) listed above.

☐ Yes ☐ No To authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

PLEASE INDICATE IF YOU HAVE ANY ADDITIONAL ACCOUNTS/RECORDS WITH OUR OFFICE THAT YOU WOULD LIKE TRANSFERRED

- ☐ Worker's Compensation Injury (Please specify date of injury): _____
- ☐ Automobile Accident Injury (Please specify date of injury): _____

FEE SCHEDULE FOR COPY SERVICES PROVIDED BY OUR MEDICAL GROUP
(charges are due at the time of the request and delivery may be will-called or sent via regular mail)

☐ **$15.00**	Flat service fee for a **digital copy** provided in a PDF format on CD. (Medical and/or Billing records)
☐ **$15.00**	Set-up charge for **hard-copy** (print to paper), plus an additional **10 cents per page**. (Medical and/or Billing records)
☐ **$30.00**	Retrieval fee for purged records requests from off site storage
☐ **No Charge**	**1**. As a professional courtesy, OptumCare Medical Group does not charge for records going to another physician for the purpose of continuing care. **2**. Any patient or former patient or the patient's representative shall be entitled to a copy, at no charge, of the relevant portion of the patient's records, upon presenting to the provider a written request, and proof that the records are needed to support an appeal regarding eligibility for a public benefit program. Although a patient shall not be limited to a single request, the patient or patient's representative shall be entitled to no more than one copy of any relevant portion of his or her record free of charge.

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.
Treatment and Benefits: I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.
Re disclosure: I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law, recipients of health care information, as specifically required or permitted by law.
Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.
Revocation: I understand that I may revoke this authorization at any time notifying my health care provider at my health care provider's corporate address. My revocation will not affect actions taken by my health care provider prior to its receipt of my written revocation.
Photocopy: A copy of this authorization is as valid as an original. I understand and agree that I have a right to receive a copy of this signed authorization and that this authorization expires (1) one year after it's signed and dated.

Date: _____ **Signature:** _____

SIGNATURE OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:
(ATTACH APPROPRIATE DOCUMENTATION) _____

PLEASE SUBMIT THIS FORM TO THE DOCTOR'S OFFICE YOU ARE REQUESTING THE RECORDS FROM